PHR*plus*
Partners for Health Reform*plus*
No. 1 - September 2002

Insights for Implementers

Decentralization and Health System Reform

Issue in brief

Decentralization is pursued for a variety of reasons: technical, political, and financial. On the technical side, it is frequently recommended as a means to improve administrative and service delivery effectiveness. Politically, decentralization usually seeks to increase local participation and autonomy, redistribute power, and reduce ethnic and/or regional tensions. On the financial side, decentralization is invoked as a means of increasing cost efficiency, giving local units greater control over resources and revenues, and sharpening accountability. However, it can also be employed (overtly or covertly) to offload financial responsibility from resource-poor central governments to regional and/or local entities.

In the health sector, when decentralization has been pursued for technical reasons, it has been a major component of performance improvement efforts. In many countries, decentralization, along with health financing reform, has figured in system reforms for at least twenty-five years. In countries where the political and financial purposes of decentralization have been primary, the health sector has had to develop coping strategies to maintain services and progress toward health objectives. In short, health sector reformers may in some cases choose decentralization, while in others decentralization may be thrust upon them.

Photo: Nena Terrell

Thus, assessing the results of decentralization experience has proven to be difficult for a number of reasons. First, as noted, a wide variety of objectives may be pursued through decentralization, and a range

of functions can be decentralized. So the combinations and permutations embodied in individual country experience can be extensive. Second, as with many concepts in the international development field, decentralization is subject to ambiguous, confusing, and conflicting definitions. This ambiguity and confusion make comparison and drawing lessons difficult. Third, the process aspects of decentralization are often in completely captured or ignored, including the lag time between putting decentralized systems in place and signs of improvements. The resulting complexity makes it hard to develop simple guidance for decision makers interested in decentralizing health systems. This document offers some help in addressing decentralization for health sector actors interested in designing decentralization policies and strategies, implementing them, and/or operating within decentralized health systems.

Definitions

Decentralization deals with the allocation between center and periphery of power, authority, and responsibility for political, economic, fiscal, and administrative systems. The focus here is on administrative decentralization for health policy, health systems management, health financing, and service delivery. The most common definitions of administrative decentralization distinguish variants along a continuum where at one end the center maintains strong control with limited power and discretion at lower levels to progressively decreasing central control and increasing local discretion at the other. This continuum can also be thought of in terms of degrees of decision space, where decentralization is assessed in terms of the range of choices available to local-level decision makers, with wider ranges being associated with higher degrees of decentralization.[1]

Decentralization has a spatial aspect in that authority and responsibility are moved to organizations in different physical locations, from the center to the local level. And it has an institutional aspect in that these transfers involve expanding roles and functions from one central agency to multiple agencies (from monopoly to pluralism). The different types of decentralization are deconcentration, delegation, and devolution, which are defined as follows:[2]

- *Deconcentration:* transfer of authority and responsibility from central agencies in a country's capital city to field offices of those agencies at a variety of levels (regional, provincial, state, and/or local).
- *Delegation:* transfer of authority and responsibility from central agencies to organizations not directly under the control of those agencies, for example, semi-autonomous entities, non-governmental organizations, and regional or local governments.
- *Devolution:* transfer of authority and responsibility from central government

[1] This is the terminology used in PHR's Major Applied Research study on decentralization (Bossert, Beauvais, and Bowser 2000).

[2] Dennis Rondinelli is the most often-cited source on the definition of decentralization in terms of these three types, to which he adds privatization. Among his many publications on the topic, Rondinelli (1990) offers a comprehensive treatment. Rondinelli and Nellis (1986) offer some lessons of experience. See also Johnson (1995) and Silverman (1992). Cohen and Peterson (1997) present an alternative definition stressing institutional pluralism. Other theoretical perspectives that inform decentralization include public choice theory and the new institutional economics. New Public Management is also a major force in advocating decentralization through an emphasis on privatization, the reduced role of the state, and the principle of subsidiarity, which holds that governance functions should be delegated to the lowest level of administration capable of handling them. See, for example, Bouckaert and Verhoest (1997).

agencies to lower- level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions.

Decentralization is not an either/or proposition. Administrative systems combine centralized and decentralized components, often in complex ways. For example, in Zambia, the central Ministry of Health delegated operational authority to a Central Board of Health (CBoH) while retaining policy and regulatory authority for itself. Operational responsibility is further deconcentrated in regional and district boards of health and hospital boards that can make some decisions independently of the CBoH. While Ghana also delegated operational authority to a Ghana Health Service (GHS) and established deconcentrated local-level budget management centers, the GHS is vested with more central authority than the Zambian CBoH. In the Philippines, a wide range of responsibilities was devolved to local government authorities, while the Medical Care Commission manages a national Medicare program and the Department of Health maintains national public health policy functions. The appropriate mix of central control and local management depends upon political, technical, and institutional factors. Real-world cases of this mix are not easy to untangle, specify, or categorize in neat typologies.

Objectives

Health reformers pursue decentralization largely to increase health sector performance, but in many cases governance and political objectives also figure importantly. The following list enumerates frequently cited objectives.[3]

- Increase service delivery effectiveness through adaptation to local conditions and targeting to local needs.
- Improve efficiency of resource utilization by incorporating local preferences into determination of service mix and expenditures.
- Increase cost-consciousness and efficiency of service production through closer links between resource allocation and utilization.
- Increase health worker motivation through local supervision and involvement of service users in oversight, performance assessment, etc.
- Improve accountability, transparency, and legitimacy by embedding health service delivery in local administrative systems.
- Increase citizen participation in health service delivery by creating systems and procedures for involvement in planning, allocation, oversight, and evaluation.
- Increase equity of service delivery by enabling marginalized and poor groups to access health care providers and to influence decisions on service mix and expenditures.
- Increase the role of the private sector in health service delivery by separating financing of health care from service provision.

Almost all decentralization strategies include several of these objectives, and in fact many of them are complementary. However, there can also be trade-offs, tensions, and conflicts. For example, deconcentrating units

[3] This list draws on Bossert, Beauvais, and Bowser (2000).

of a health ministry may increase the efficiency of resource allocation by allowing health facility managers to make decisions about purchasing supplies or replenishing medicine stocks, but may not empower service users and beneficiaries to have a say in allocation decisions, such as when staff are present to provide services to the most users at convenient hours or whether physicians are available in addition to nurses. Local staff of the ministry may resist community input on the grounds that such participation is costly and that health professionals know best what services and medications should be provided, when, and by what level of health manpower.

Another example of the tensions that can be introduced is when decentralization reforms compromise the quality of services. Analysis of immunization programs, for example, has shown that when EPI (Expanded Program on Immunization) is delegated to the local level there can be increased risk of problems such as improper cold chain maintenance, purchase and use of unsuitable equipment, reduced clinical supervision, and diminished outreach (see, for example, Fielden and Nielsen 2001).

Photo: Jessica Rushing

Functions

Disaggregating decentralization is usually done by function. When combined with the different types of decentralization, a matrix is produced that can be used for planning, design, and assessment purposes. Table 1 illustrates a more or less standard set of functions and can help map out the situation for a particular country's health system.[4]

A variant of mapping the type of decentralization by broad category (deconcentration, delegation, or devolution) is to assess the degree of decision space, or range of choice (narrow, moderate, or wide) that local authorities have for various functions.[5] Table 2, developed from PHR's decentralization research and published in Bossert and Beauvais (2002: 17), illustrates this approach with applications to Ghana, Zambia, Uganda, and the Philippines. Both of these maps can help to clarify the decentralization "picture" for a particular health system and identify sources of tension, current or potential capacity problems, and political and/or bureaucratic concerns.

[4] This list of functions is a compilation of Bossert, Beauvais, and Bowser (2000), MSH (n.d.), and Silverman (1992). Bossert substitutes degree of discretion in decision making for the three types of decentralization in his matrix.

[5] Indicators for mapping decision space can be found in Annex A of Bossert, Beauvais, and Bowser (2000). Rankings of narrow, moderate, and wide are based upon factors such as: intergovernmental transfers as a percentage of total local health spending; percentage of local spending earmarked by higher authorities; and extent to which higher authorities determine choices on services, payment mechanisms, staffing, etc.



Table 1. Decentralization Types and Health Sector Management Functions

Functions	Types of Administrative Decentralization		
	Deconcentration	Delegation	Devolution
Planning Decentralization ■ Policy formulation ■ Program/project design			
Finance ■ Revenue generation and sources ■ Budgeting, revenue allocation ■ Expenditure management and accounting ■ Financial audit			
Human Resources ■ Staffing (planning, hiring, firing, evaluation) ■ Salaries and benefits ■ Training			
Service Delivery and Program/ Project Implementation ■ Defining service packages (primary care, tertiary care) ■ Targeting service delivery ■ Setting norms, standards, regulations ■ Monitoring and oversight of service providers ■ User participation ■ Managing insurance schemes ■ Contracting			
Operation Maintenance ■ Drugs and supplies (ordering, payment, inventory) ■ Vehicles and equipment ■ Facilities and infrastructure			
Information Management ■ Health information systems design ■ Data collection, processing, and analysis ■ Dissemination of information to various stakeholders			



Table 2. Comparative Decision Space: Ghana, Philippines, Uganda, and Zambia

Function	Degree of Decision Space		
	Narrow	Moderate	Wide
Financing			
■ Sources of revenue	Zambia	Ghana, Uganda	Philippines
■ Expenditures		All four	
■ Income from fees		Ghana, Uganda, Zambia	Philippines
Service organization			
■ Hospital autonomy	Ghana, Zambia	Uganda	Philippines
■ Insurance plans	Ghana, Uganda		Philippines, Zambia
■ Payment mechanisms	Ghana, Uganda	Philippines	Zambia
■ Contracts with private providers		Zambia	Uganda
Human resources			
■ Salaries	All four		
■ Contracts	Ghana	Philippines	Uganda, Zambia
■ Civil service	Ghana	Philippines, Uganda, Zambia	
Access rules	Ghana	Philippines, Uganda, Zambia	
Governance			
■ Local government	Ghana, Zambia		Philippines, Uganda
■ Facility boards	All four		
■ Health offices	Ghana, Philippines	Uganda, Zambia	
■ Community participation	Ghana, Uganda	Philippines, Zambia	

Critical Issues

A number of issues and problems are frequently encountered in designing and implementing health sector decentralization.

Mismatch between authority and responsibility. This problem can be found in many different forms, for instance, within sectoral decentralization efforts or between administrative and fiscal decentralization. An example of the former is when responsibility for managing public health workers is delegated to regional or municipal health units, but the central ministry retains authority for hiring, firing, and promotion of staff. An example of the latter is where local governments are responsible for health care spending, but have no revenue-raising authority. Another variant arises when central units assign additional responsibilities to regional or local health sector agencies, but provide no additional resources (unfunded mandates). The authority–responsibility mismatch is frequently found in relation to revenue-raising/spending and personnel decisions.

Further complications can arise when administrative boundaries of deconcentrated health districts are not contiguous with those of devolved local government authorities. In these situations, different degrees of both authority and responsibilities for health must somehow be aligned and coordinated to serve

population catchment areas that may lie within one health district and two separate local government authorities, or vice versa.

Tensions and conflicts among objectives. These can be manifested, for example, in shifts in service mix away from priority services – one of the most frequently cited and predicted outcomes of health sector decentralization. In some cases, devolution can lead local health providers to respond to local preferences for curative rather than preventive and primary health services. While the objective of responsiveness to local preferences may be met, from the standpoint of the national health system, the result is a sub-optimal allocation of resources. In some cases, health care of any type may be less of a priority for local government than investment in some other sector, the result being that health is starved of resources. Many countries provide examples of this consequence, especially in early stages of decentralization.

Dealing with tensions and conflicts can be addressed first of all by providing central guidelines or requirements (e.g., for matching funds) that can counter local government pressures for underfunding health services. Various formulas for transferring central funds to local levels can be devised to include set-asides, required percentages for health (earmarking), and/or weights for districts with higher proportions of at-risk or poor populations. Second, some functions can be retained at the central level, such as, for example, procurement of essential drugs, certain elements of EPI, etc. However, there will always be trade-offs. For example, in some circumstances, imposing central priorities could undermine local accountability and influence health worker motivation; it could also result in unintended consequences for equity or efficiency. There are no simple answers.[6]

Capacity gaps. A classic issue in decentralization is lack of capacity. In many countries, deconcentrated units of the health ministry are both technically and administratively weak. In addition, as the role of the center shifts toward supporting decentralized service delivery, central-level regulation and oversight skills are often in short supply. In some cases, local governments may not have the capacity to encourage community involvement in governance, including health services. Further, the poor and marginalized tend to be ill equipped to mobilize for the participatory opportunities decentralization can offer. When decentralization transfers spending and revenue-raising authority, lack of administrative capacity can lead to financial mismanagement, waste of resources, and corruption. This situation is often referred to as simply localizing corruption and other management problems that previously existed at the central-level.

Tensions between vertical and horizontal integration. The "stovepipe" phenomenon associated with vertical programs, and the donor funding that accompanies them, is well recognized. If local health services consist mainly of a collection of vertical programs funded by central ministries of health (and donors), local decision-making discretion will be quite low, and decentralization will be limited at best to deconcentration. Delegation and/or devolution to achieve integrated service delivery at the local level need to offset the effects of these vertical lines of control. The establishment of district health committees to carry out planning, management, and financial oversight functions is a classic organizational response to this issue. Evidence on the effectiveness of this response is, however, mixed.

[6] See Mills (1994) and Smith (1997) for further discussion of these tensions and contradictions.

Political and process dimensions. As many observers have noted, decentralization is profoundly political. Groups with a vested interest in the status quo and who will lose power, influence, and resources as a result of administration or fiscal decentralization often oppose it. While there may be strong technical arguments in favor of health sector decentralization, without attention to the politics of decentralization, reforms may fail to yield the expected increases in efficiency, effectiveness, and equity. These political dynamics are especially important because decentralization reforms do not take place overnight. The reform process can be an extended one, even if the implementation strategy aims for a comprehensive, big push. Without signs of success, support for decentralization may wane, leading to reversals. The process dimension of decentralization highlights the importance of stakeholder participation, effective communication, and political will.

Photo: Bryn Sakagawa

Guidance and Lessons

The following bullets offer some guidance and lessons. These are divided by reform stages: design, implementation, and evaluation.

Design

Many governments and ministries of health have already made key design decisions about decentralization reforms and are in the process of implementing them, some for many years. In other cases, implementation is in early stages, decentralization processes have stalled, and initial decisions are under review. In most of these cases, some design or redesign work may be relevant.

- Identify the main planning, financing, human resource, service delivery, operational, and/or information functions that some degree of decentralization would improve.
- Identify the objectives of decentralization for each of those functions.
- Consider carefully which decisions would be made most effectively at the central level and which at the local levels, by local health or local government authorities. Do this in light of the objectives and the capacities.
- Map out the current administrative and financing structure and identify potential sources of tension, conflicts, capacity problems, and political issues.
- Consider building in phased implementation, capacity building, feedback mechanisms, and monitoring and evaluation (M&E) plans.



Implementation

- Identify major stakeholders, clarifying potential winners and losers (some of this can be done during design).
- Develop plans for negotiation, compromise, advocacy, and problem solving to overcome stakeholder issues.
- Maintain a monitoring system for key policy processes and interim results related to the objectives of the decentralization.
- Establish and enforce a feedback and decision process for using monitoring information to keep decentralization reforms on track and/or make mid-course corrections.
- Where possible and relevant, consider pilot testing decentralization components that are likely to be most problematic and for which particular consensus may need to be built.

Evaluation

- Using the objectives of the decentralization, establish an M&E plan that uses routine monitoring information in combination with periodic field reviews.
- To avoid unintended consequences, consider developing a longer-term evaluation design that measures the impact of the decentralization on the major objectives of the program, as well as on bigger picture health sector objectives in the country.
- To the extent possible, be careful to design an evaluation strategy that can identify results due to decentralization versus other factors that may be contributing to that result, such as a decline in utilization of priority services. For example, major economic downtowns, currency devaluation, political upheaval, reductions in donor-provided vaccines, and/or skyrocketing gasoline prices that slow transport and delivery of medicines may be happening simultaneously.

PHRplus Tools and Tips

All PHR*plus* reports can be downloaded from www.PHRproject.com.

Analysis of Decentralization in the Health Sector of Paraguay at the Departmental Level.
Order No. TE 3

Assessment of Health Sector Decentralization in Paraguay.
Order No. TE 1

A Strategic Plan for Decentralizing the Health System in Paraguay.
Order No. TE 4

Decentralization of Health Systems: Preliminary Review of Four Country Case Studies.
Order No. MAR 6, TE 1

Decentralization of the Health System in Zambia.
Order No. MAR 6, TE 2



Décentralisation et système de santé au Sénégal: Une synthèse. Order No. TE 62

H*ealth Zones, Co-management, and Decentralization in Benin.* Order No. TE 52

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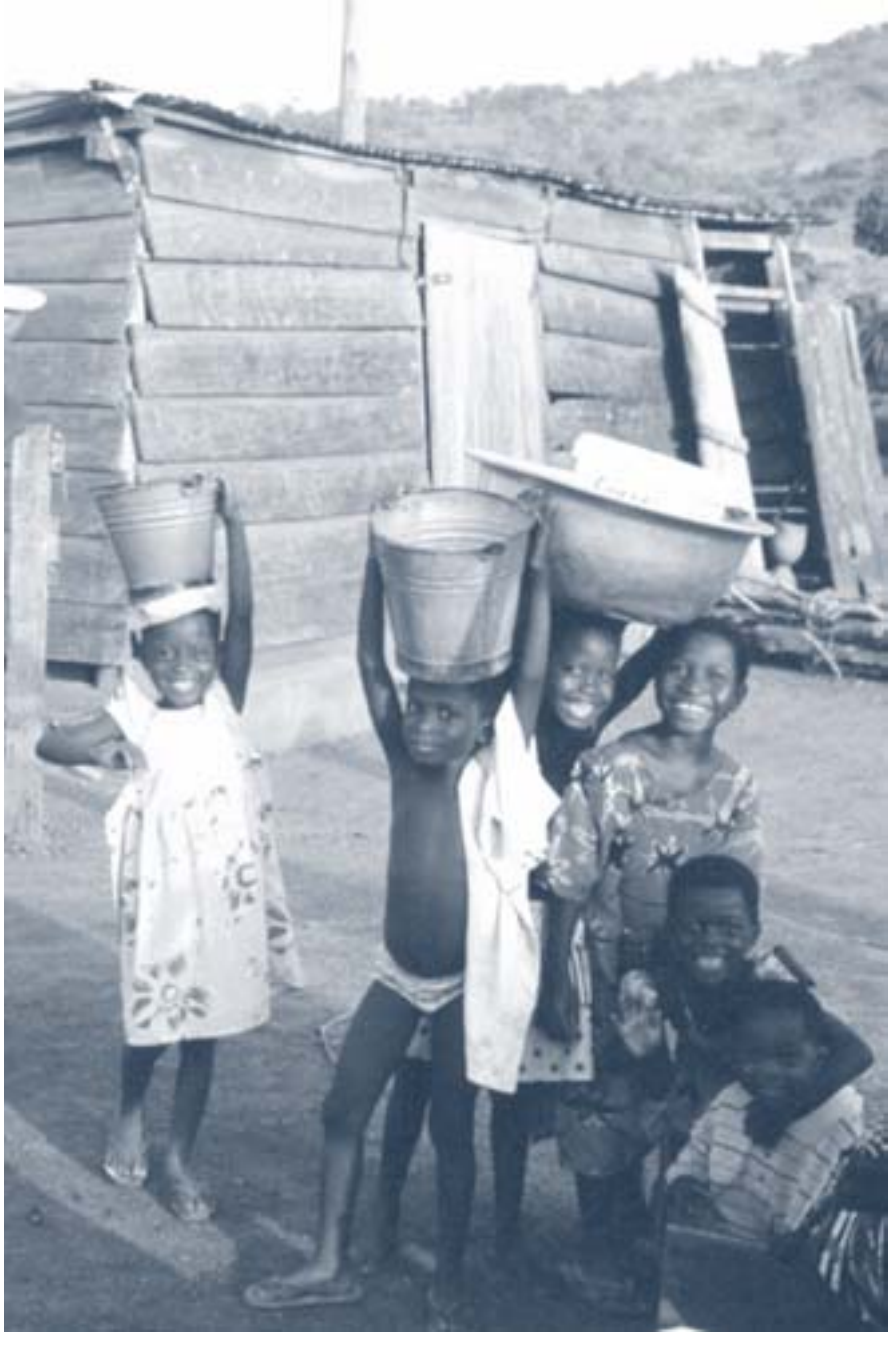

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Partners for Health Reform*plus* (PHR*plus*) is funded by USAID and implemented by Abt Associates Inc. and partners Development Associates, Inc.; Emory University Rollins School of Public Health; Program for Appropriate Technology in Health; Social Sectors Development Strategies, Inc.; Training Resources Group; Tulane University School of Public Health and Tropical Medicine; and University Research Co., LLC.

Insights for Implementers: Decentralization and Health System Reform was written by Derick Brinkerhoff, EdD; and Charlotte Leighton, PhD. The authors thank Nancy Pielemeier, DrPH; Mary Paterson, PhD; and Stephen Musau, B.Com, FCA for helpful comments on earlier drafts.

Insights for Implementers is designed to help PHR*plus* counterparts grasp our strategy and approach to select technical areas. This issue was edited by Linda Moll and Zuheir Al-Faqih, and designed and produced by Michelle Hamadeh. For additional copies, please contact us or visit the project website:

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